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Keep Smiling

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 22 April 2015. CQC inspected the practice on 5 April 2014 and identified areas thet needed improvement in regards to infection prevention and control. We asked the provider to make improvements regarding this breach and asked the provider to submit an action plan on how they intended to make improvements. We checked these areas as part of this comprehensive inspection and found that they were resolved.

The practice has one dentist who is also the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

The dentist is supported by an associate dentist who works part time and three dental nurses who also work as receptionists.

The practice provides primary dental services to mainly NHS patients. The practice is open Monday to Friday between the hours of 9.15am and 5.15pm. The practice is also open from 9am to 1pm on Saturdays.

We spoke with one patient during the inspection. They told us that they were very satisfied with the services provided, that the dentists provided them with clear explanations about their care and treatment, that costs were clear and that all staff treated them with dignity and respect.

We viewed CQC comment cards that had been left for patients to complete, prior to our visit, about the services provided. There were 11 completed comment cards and all of them reflected positive comments about the staff and the services provided. Patients commented that the practice was clean and hygienic, they found it easy to book an appointment and they found the quality of the dentistry to be very good. They said explanations were clear and that the staff were kind, caring and reassuring. Patients also commented positively that there was always a dentist available when urgent treatment was required.

We found that this practice was providing safe, effective, caring, responsive and well-led care in accordance with the relevant regulations.

Our key findings were:

- The practice had a system in place to record significant events, safety issues and complaints and to cascade learning to staff.
- Staff had received safeguarding training and knew the processes to follow to raise any concerns.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients

Summary of findings

- Staff had been trained to handle emergencies and appropriate medicines were readily available.
- Infection control procedures were robust and staff were able to demonstrate how they followed the published guidance.
- Patient's care and treatment was planned and delivered in line with evidence based guidelines, best practice and current legislation.
- Patients received clear explanations about their proposed treatment, costs, benefits and risks and were involved in decisions about it.
- Patients were treated with dignity and respect and confidentiality was maintained.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- The practice staff felt involved and worked as a team.
- There was a range of clinical and non-clinical audits to monitor the quality of services.
- The practice sought feedback from patients about the services they provided.

There were areas where the provider could make improvements and should:

- Ensure a business continuity plan is developed and has a comprehensive process for recovering from unexpected events that threaten the stability of the practice.
- Review the practice's protocols and procedures for promoting the maintenance of good oral health giving due regard to guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'.
- Have arrangements in place to provide access to translation services.
- Ensure all audits have learning points documented learning points of audits are carried out to demonstrate improvement.
- Ensure feedback received from patients is regularly analysed and responded to appropriately.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this practice was providing care which was safe in accordance with the relevant regulations. There were systems in place to help ensure the safety of staff and patients. These included safeguarding children and adults from abuse and maintaining the required standards of infection prevention and control. The practice carried out and reviewed risk assessments to identify and manage risk. A system was in place to record significant events, complaints and accidents. Staff were suitably trained and skilled to meet patient needs and there were sufficient numbers of staff available at all times. Infection control procedures were robust and staff had received training. Emergency medicines in use at the practice were stored safely and checked to ensure they did not go beyond their expiry dates. Sufficient quantities of equipment were in use at the practice.

Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations. Patients received an assessment of their dental needs including taking a medical history. Explanations were given to patients in a way they understood and risks, benefits, options and costs were explained. Staff were supported through training, appraisals and opportunities for development. Patients were referred to other services in a timely manner. Staff had received training in and understood the Mental Capacity Act.

Are services caring?

We found that this practice was caring in accordance with the relevant regulations. Patients were treated with dignity and respect and their privacy maintained. Patient information and data was handled confidentially. Patients told us they were listened to and not rushed. Treatment was clearly explained and they were provided with written treatment plans. Patients with urgent dental needs or in pain were responded to in a timely manner, often on the same day.

Are services responsive to people's needs?

We found that this practice was providing responsive care in accordance with the relevant regulations. Appointment times met the needs of patients and waiting time was kept to a minimum.

Information about emergency treatment was made available to patients. A practice leaflet was available in reception to explain to patients about the services provided. The practice had made reasonable adjustments to accommodate patients with a disability or lack of mobility.

Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations. The practice staff were involved in leading the practice to deliver satisfactory care. Care and treatment records were audited to ensure standards had been maintained. Staff were supported to maintain their professional development and skills. A range of clinical and non-clinical audits were taking place. The practice sought the views of patients but did not always document the actions taken to improve patient safety and their overall experience. Health and safety risks had been identified, which were monitored and reviewed regularly.

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Detailed findings

Background to this inspection

The inspection took place on 22 April 2015 and was conducted by a CQC inspector who had access to a remote advice from a dentistry advisor.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Prior to the inspection we asked the practice to send us some information which we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, the details of their staff members and their qualifications and proof of registration with their professional bodies.

We also reviewed the information we held about the practice. During the inspection we spoke with the dentist and three dental nurses. We reviewed policies, procedures and other documents. We also spoke with one patient and reviewed 11 CQC comment cards that we had left prior to the inspection, for patients to complete, about the services provided at the practice.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Systems were in place to record incidents and the health and safety policy informed staff of their process. The practice recorded incidents in the accidents book. We saw that one incident had been recorded in June 2011 and another had been recorded in January 2015.

The practice had not received any complaints in the last twelve months but we saw that a verbal complaint had been received in September 2013. We saw that the complaint had been responded to appropriately. Staff meetings took place monthly and although there were no other incidents to comment upon, we were satisfied that the meetings were being used to cascade relevant safety information to staff.

The practice responded to national patient safety and medicines alerts that affected the dental profession. Staff members showed us a folder of alerts that had been received by the practice. We saw that the last alert received by the practice was May 2013. The dentist told us that they now received them via email and acted on them where appropriate. Staff we spoke with displayed a satisfactory knowledge of the alerts that affected dental practices.

A medical history record was taken from each patient and updated each time they attended. These were in hard copy and recorded on the patient record on their IT system. Paper records reflected that medical histories were being updated and they had been dated and signed.

Records we viewed reflected that the practice had undertaken a risk assessment in relation to the control of substances hazardous to health (COSHH). Each type of substance used at the practice that had a potential risk was recorded and graded as to the risk to staff and patients. Measures were clearly identified to reduce such risks including the wearing of personal protective equipment and safe storage.

Reliable safety systems and processes (including safeguarding)

All staff at the practice were trained in safeguarding and there was an identified lead who was the dentist. Staff we spoke with were aware of the different types of abuse and who to report them to if they came across a vulnerable child or adult. A policy was in place for staff to refer to and this contained telephone numbers of who to contact outside of the practice if there was a need. There had been no safeguarding incidents since they had registered in 2013.

Staff spoken with on the day of the inspection were aware of whistleblowing procedures and who to contact outside of the practice if they felt that they could not raise any issue with the dentists or practice manager. However, they felt confident that any issue would be taken seriously and action taken.

Medical emergencies

Emergency medicines, a first aid kit and oxygen were readily available if required. All staff had been trained in basic life support and had attended a course on managing medical emergencies in dental practices. All emergency equipment was readily available and staff knew how to access it. We checked the emergency equipment and medicines and found that it contained the recommended type and it was all in date. A system was in place to check it regularly for stock control and expiry date purposes and records had been kept.

Emergency medicines and oxygen were readily available if required. All staff had been trained in basic life support were able to respond to a medical emergency. We saw an incident recorded recently which showed that staff acted appropriately to a medical emergency.

The practice did not have an External Automated Defibrillator (AED). An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. The dentist was unaware that an AED was a requirement. The dentist confirmed they had purchased an AED after the inspection by providing a copy of the purchase invoice.

Staff recruitment

The practice had a recruitment policy that described the process when employing new staff. This included obtaining proof of identity, checking skills and qualifications, registration with professional bodies where relevant, references and whether a Disclosure and Barring Service

Are services safe?

check was required. We looked at three staff files and found that the process had been followed. Each file contained the necessary documentation to confirm that staff were suitably trained and qualified.

The practice had one full time dentist who was the provider and a part time associate dentist with three qualified nurses who also worked in reception. The dentist told us that there was always three nurses working at the practice and therefore always an extra member of staff available. On the day of the inspection we saw there were sufficient numbers of suitably qualified and skilled staff working at the practice. A system was in place to ensure that where absences occurred, staff were able to cover for each other. On the rare occasion this was not possible agency staff were used and their skills and qualifications checked before being allowed to work at the practice. The dentist also told us that they owned another practice nearby and if needed staff from the other site would be able to cover.

Monitoring health & safety and responding to risks

A health and safety policy and risk assessment was in place at the practice. This identified risks to staff and patients who attended the practice. The risks had been identified and control measures put in place to reduce them. A fire risk assessment was in place and weekly checks for fire alarm, extinguishers and emergency lighting was in place.

There were other policies and procedures in place to manage risks at the practice. These included infection prevention and control, a legionella risk assessment, fire evacuation procedures and risks associated with Hepatitis B. Processes were in place to monitor and reduce these risks so that staff and patients were safe.

Infection control

The practice was visibly clean, tidy and uncluttered. Staff were responsible for the cleaning of the practice and we saw detailed cleaning schedules were in place which showed the areas and frequency of cleaning tasks completed. An infection control policy was in place with a named lead. There were protocols in place in both surgeries for cleaning of dental water lines and the cross infection procedures after each patient. Annual Health Technical Memorandum 01-05 (HTM 01-05) audits were being carried out with the last audits carried out in December 2014. HTM01-05 is the Department of Health's guidance on decontamination in primary care dental practices. We saw records that staff had received training in HTM 01-05 as part of their continual professional development (CPD).

We found that there were adequate supplies of liquid soaps and hand towels in the practice. Posters describing proper hand washing techniques were displayed in the dental surgeries, the decontamination room and the toilet facilities. Sharps bins were properly located, signed, dated and not overfilled. A clinical waste contract was in place and waste materials were stored securely until collection.

During our previous inspection in April 2014 we found that patients were not protected from the risk of infection because appropriate guidance had not been followed. During that inspection we saw that some areas of the surgery that had a problem of penetrating dampness. We also saw that the flooring in the clinical areas were inadequate and a dental chair in one of the surgeries had tears which would not allow for effective cleaning.

At this inspection we saw that this had been addressed and the surgery had been renovated and the issue causing the damp had been resolved. New flooring had been installed throughout the practice including the reception area and a new dental chair had been purchased. The provider also showed us that they had purchased new automatic sensor waste bins which enabled better infection control.

We looked at the procedures in place for the decontamination of re-usable dental instruments. The practice had a dedicated decontamination room that was set out according to the

Department of Health's guidance HTM 01-05. Each of the dental surgeries had direct access to the decontamination room to facilitate the transportation of instruments safely. The decontamination room had clearly defined dirty and clean zones in operation to reduce the risk of cross contamination. Staff demonstrated the process to us including how they wore appropriate personal protective equipment such as disposable gloves, aprons and protective eye wear.

The autoclave used for sterilising was maintained and serviced as set out by the manufacturers' guidance. Daily, weekly and monthly records were kept of operating cycles and tests and when we checked those records it was evident that the equipment was in good working order and being effectively maintained.

Are services safe?

The practice had an up to date legionella risk assessment in place and conducted regular tests on the water supply. This included maintaining records and checking on the hot and cold water temperatures achieved.

Equipment and medicines

Records we viewed reflected that equipment in use at the practice was regularly maintained and serviced in line with manufacturers guidelines. Portable appliance testing (PAT) took place on all electrical equipment. Fire extinguishers were checked and serviced regularly by an external company and staff had been trained in the use of equipment and evacuation procedures.

X-ray machines were the subject of regular visible checks and records had been kept. A specialist company attended at regular intervals to calibrate all X-ray equipment to ensure they were operating safely.

Medicines in use at the practice were stored and disposed of in line with published guidance. Medicines in use were checked and found to be in date. There were sufficient stocks available for use. Emergency medical equipment was monitored regularly to ensure it was in working order.

Radiography (X-rays)

X-rays were carried out safely and in line with local rules that were relevant to the practice and equipment. These were displayed next to the X-ray.

A radiation protection advisor and a radiation protection supervisor had been appointed to ensure that the equipment was operated safely and by qualified staff only. This protected people who required X-rays to be taken as part of their treatment. The practice's radiation protection file contained the necessary documentation demonstrating the maintenance of the X-ray equipment at the recommended intervals. Records we viewed demonstrated that the X-ray equipment was regularly tested, serviced and repairs undertaken when necessary.

The practice monitored the quality of the X-rays on a regular basis and records were being maintained. For example, we saw an audit on the quality of X-rays carried out in February 2015 which did not identify any issues. This ensured that they were of the required standard and highlighted any areas for improvements, which were acted upon and reduced the risk of patients being subjected to further unnecessary X-rays. Patients were required to complete medical history forms to assess whether it was safe for them to receive X-rays. This included identifying where patients might be pregnant.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice had policies and procedures in place for assessing and treating patients. Patients attending the practice for a consultation received an assessment of their dental health after providing a medical history covering health conditions, current medicines being taken and whether they had any allergies.

We looked at a sample of 10 patient records and found that the assessments were carried out in line with recognised guidance from the National Institute for Health and Care Excellence (NICE) and General Dental Council (GDC) guidelines. This assessment included an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. We spoke with the dentist who showed us some of the NICE guidance they followed.

We saw that each person's diagnosis was discussed with them and treatment options were explained. Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included smoking cessation advice and general dental hygiene procedures. Where appropriate dental fluoride treatments were prescribed. For example, we saw a prescription audit where patients had been prescribed high fluoride toothpaste. The patient notes were updated with the proposed treatment after discussing options with the patient. Patients were monitored through follow-up appointments and these were scheduled in line with NICE recommendations.

Patients requiring specialised treatment such as conscious sedation or orthodontics were referred to other dental specialists. Their treatment was then monitored by the practice after it had taken place to ensure they received a satisfactory outcome and all necessary post procedure care.

We spoke with one patient and reviewed 11 CQC comment cards. Feedback we received reflected that patients were very satisfied with the assessments, explanations, the quality of the dentistry and outcomes.

The practice did not have a business continuity plan to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service. Staff and the dentist we spoke with told us that they will look to develop a plan.

Health promotion & prevention

The waiting room and reception area at the practice contained a range of literature that explained the services offered at the practice in addition to information about effective dental hygiene and how to reduce the risk of poor dental health. This included information on how to maintain good oral hygiene both for children and adults and the impact of diet, tobacco and alcohol consumption on oral health. Patients were advised of the importance of having regular dental check-ups as part of maintaining good oral health. We saw training records where the dentist and the staff had attended core training which included training on smoking cessation and oral cancer.

We saw evidence and the dentist was able to provide specific examples where they had advised children and their parents attending the practice for consultation with advice on the steps to take to maintain healthy teeth. However, we found a limited application of guidance issued in the DH publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Staffing

The practice employed three dental nurses who also worked in reception and a dental associate who worked part time. Dental staff were appropriately trained and registered with their professional body. Staff were encouraged to maintain their continuing professional development (CPD) to maintain their skill levels. CPD is a compulsory requirement of registration as a general dental professional and its activity contributes to their professional development. Staff files we looked at showed details of the number of hours they had undertaken and training certificates were also in place.

Staff training was being monitored and training updates and refresher courses were provided. The practice had identified some training that was mandatory and this included basic life support and safeguarding. Records we

Are services effective?

(for example, treatment is effective)

viewed showed that staff were up to date with this training. Staff we spoke with told us that they were supported in their learning and development and to maintain their professional registration.

The practice has procedures in place for appraising staff performance and records we reviewed showed that appraisals had taken place. Staff spoken with said they felt supported and involved in discussions about their personal development. They told us that the principal dentist who was also the provider was supportive and always available for advice and guidance.

The practice had an induction system for new staff. Records we looked at showed that there was an induction checklist with induction to infection prevention and control. However, no staff had been recruited since 2006.

Working with other services

The practice had systems in place to refer patients to other practices or specialists if the treatment required was not provided by the practice. There was a referral folder in the practice and we saw that 22 patients had been referred this year so far. This included referral for specialists' treatments such as orthodontics, patients with complex needs such as those on warfarin as well as for extractions. We saw records where patients were referred to the Birmingham Dental Hospital (BDH) for second opinions for cases such as cancer before commencement of treatment.

Consent to care and treatment

We looked at the dental care records of 10 patients. We saw evidence that patients were presented with treatment options and consent forms which were signed by the patient. A patient we spoke with also advised they gave both verbal and written consent to their treatment. Training records we looked at showed that staff had attended Mental Capacity Act 2005 (MCA). MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The dentist we spoke with was also aware of and understood the use of Gillick competency in young persons. Gillick competence is used to decide whether a child (16 years or younger) is able to consent to their own medical treatment without the need for parental permission or knowledge.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The practice had procedures in place for respecting patient's privacy, dignity and providing compassionate care and treatment. We observed that staff at the practice treated patients with dignity and respect and maintained their privacy. The reception area was open plan but we were told by reception staff/dental nurse that they considered privacy during conversations held at the reception area when other patients were present. They also confirmed that should a confidential matter arise, a private area or a free surgery was available for use. Staff members we spoke with told us that they never asked patients questions related to personal information at reception. Instead they showed them details such as their date of birth and address on record and asked them to confirm.

A data protection and confidentiality policy was in place of which staff were aware. This covered disclosure of, and the secure handling of patient information. We observed the interaction between staff and patients and found that confidentiality was being maintained. We saw that patient records, both paper and electronic were held securely.

A patient we spoke with and those who completed comment cards said that they felt that practice staff were kind and caring and that they were treated with dignity and respect and were helpful. A patient commented how the dentist and staff spoke with them about 'normal things' during treatment to reduce nervousness and anxiety about their treatment. Staff members told us that longer appointment times were available for patients who required extra time or support, such as patients with learning disabilities.

Involvement in decisions about care and treatment

A patient we spoke with told us that the dentist listened to them and they felt involved with the decisions about their care and treatment. They told us that consultations and treatment were explained to them in a way they understood, followed up by a written treatment plan that was clear and that explained the costs involved.

We looked at some examples of written treatment plans and found that they explained the treatment required and outlined the costs involved.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient's needs

The practice information leaflet displayed in the waiting area described the range of services offered to patients, the complaints procedure, information about practice opening times, patient confidentiality and emergency care.

Appointment times and availability met the needs of patients. The practice was open from 9.15am to 5.15pm. Patients with emergencies were seen within 24 hours of contacting the practice, sooner if possible. The practice was also open from 9am to 1pm on Saturdays. Patients who completed CQC comment cards prior to our inspection stated that they were rarely kept waiting and they could obtain appointments when they needed one. One patient commented that they were seen straight away during an emergency.

Staff we spoke with told us that most patients were registered with the practice were South Asian. They told us that most of the staff were able to speak the languages spoken by these patients including, Punjabi, Urdu and Bengali. They told us that other patients such as Polish or Somalian patients were able to speak English or usually were accompanied by someone who spoke English so that they could translate. Staff were not aware of any translations service they could use in the event they needed a translator. However, they stated that they would look into this so that they were in a position to arrange one should a need arise. We saw that a hearing loop was available for patients who had difficulty with their hearing.

Tackling inequity and promoting equality

The practice had step free access to assist patients with mobility issues, using wheelchairs or parents with prams or pushchairs. Practice staff were aware of the patients that attended with limited mobility and told us they supported them when they arrived. A patient we spoke with told us that they had some mobility issues and staff always helped them to access the practice.

The practice had an equality and diversity policy that staff were required to read. This supported them in understanding the different types of cultures and beliefs of some of their patients. We looked at staff files and saw that they had attended training as part of their CPD in ethical and legal issues. The dentist and staff explained that this training covered issues around equality and diversity. The dentist and staff we spoke with displayed understanding of the cultural needs of some of their patients.

The dentist also told us that they were open Saturdays between 9pm and 1pm. This enabled working patients and children to attend without taking time out from work or school.

We saw that the practice had conducted a Disability Discrimination Act (DDA) assessment and was aware of the limitations. DDA works to protect people with disabilities by encouraging service providers to make reasonable adjustments. The DDA act has been repealed and replaced by the Equality Act 2010.

Access to the service

Patients could access care and treatment in a timely way and the appointment system met the needs of patients. Where treatment was urgent patients would be seen the same day if necessary. Saturday appointments were available.

CQC comment cards we reviewed and a patient we spoke with told us that the availability of appointments met their needs and they were rarely kept waiting. They said they had no problems obtaining an appointment of their choice.

The arrangements for obtaining emergency dental treatment were clearly displayed outside the surgery, in the waiting room area and in the practice leaflet.

Staff we spoke with told us that patients could access appointments when they wanted them and patients we spoke with and CQC comment cards we viewed confirmed this.

Concerns & complaints

The practice had a complaint procedure and policy. The complaints policy was displayed in the waiting area and the practice leaflet also informed patients of the complaints process. Staff we spoke with were aware of the procedure to follow if they received a complaint.

The practice had not received any written complaints and a patient we spoke with on the day of our inspection told us that they had not had any cause to complain but felt that staff at the practice would treat any matter seriously. We reviewed 11 CQC comments cards received from patients and they were all very positive about the service and staff.

Are services well-led?

Our findings

Governance arrangements

The practice had arrangements in place for monitoring and improving the services provided for patients. Staff we spoke with were aware of their roles and responsibilities within the practice.

There was a full range of policies and procedures in use at the practice. These included health and safety, infection prevention control, patient confidentiality and recruitment. Staff we spoke with were aware of the policies and they were readily available for them to access.

We found that there were a number of clinical and non-clinical audits taking place at the practice. These included infection control, patient records, X-ray quality and prescribing audits. Where areas for improvement had been identified action had been taken. Some of the audits such as prescribing audits did not detail the learning points. However, staff spoken with were able to tell us the learning points from the audit and the actions taken. Also, some audits carried out did not show how improvements were being maintained through regular re-audits.

The practice showed us a clinical governance quality and safety self-assessment tool that was used by the Primary Care Trust (PCT) and now replaced by the Clinical Commissioning Groups (CCG). CCGs are groups of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. Staff told us that they still used this toolkit as they found it a useful aid for reviewing their governance arrangements and for updating their policies and procedures.

Leadership, openness and transparency

The team consisted of three dental nurses, one part time dental associate and the principal dentist. Staff told us that meetings took place quarterly and there were some minutes of minutes. However, staff told us that they had ad hoc meetings regularly due to the small team and any issues were resolved quickly. Staff spoken with were aware of all relevant safety and quality issues including learning.

There was no practice manager but it was clear that the dental nurses worked as a team to deliver an effective service. One of the dental nurse took a lead role in many of management activities in conjunction with the dentist.

Staff spoken with felt empowered and told us that the dentist encouraged them to report safety issues and they felt confident to raise any concerns they had. These were discussed openly at staff meetings where relevant.

All staff were aware of whom to raise any issue with and told us that the dentist would listen to their concerns and act appropriately. We were told that there was a no blame culture at the practice and that the delivery of high quality care was part of the practice ethos.

Management lead through learning and improvement

A number of clinical and non-clinical audits on patients who failed to attend their appointment (DNA). Staff explained that they wrote to had taken place where improvement areas had been identified. For example, we saw an audit conducted patients if they missed two appointments. Our discussion with staff members confirmed that the outcomes for all audits were discussed with all staff members.

Staff appraisals were used to identify training and development needs that would provide staff with additional skills and to improve the experience of patients at the practice. Staff spoke very positively about the open culture within the practice. They told us that there were opportunities for learning and personal development.

We saw staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC). The dentist we spoke with told us that they subscribed to dental update magazine and had attended 40 hours of CPD this year. They explained that the requirement was only 15 hours per year.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had conducted a recent patient survey by asking patients to complete a questionnaire about the services they provided. The practice had a comments box which was reviewed regularly. We saw that the comments received were positive. The practice also had a comments book and most comments we reviewed were positive. We saw that patients had made some suggestions for improvement on both the comments box and the comments book. Staff told us that these suggestions were not realistic. However, the practice was not feeding back to patients so that they knew their comments were

Are services well-led?

acknowledged. Furthermore, the practice did not document any analysis of patient comments and suggestions to identify themes and trends which may help improve the service.

Staff we spoke with told us their views were sought at appraisals, team meetings and informally. They told us their views were listened to, ideas adopted and they felt part of a team. For example, staff told us that they were involved in choosing the colour of the new flooring that was recently laid in the practice.